1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12428 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12407

1. PLACE OF DEATH
a. COUNTY Caroline MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE Maryland b. COUNTY Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: LINDA Middle: ARABELLA Last: CARLISLE
4. DATE OF DEATH Month: NOV Day: 17 Year: 1960
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 8, 1890
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Anthony
14. MOTHER'S MAIDEN NAME: Josephine Truitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: John Carlisle
Address: Greensboro Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 24 Hrs.
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. ~~Nov 17 1960~~
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) Denton Caroline Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Dawson D. George M.D.
EXAMINER'S NAME (Type) Dawson D. George MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) Denton, Caroline
DATE SIGNED 11-17-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 20, 1960
22c. NAME OF CEMETERY OR CREMATORY: Denton
22d. LOCATION (City, town, or country) (State): Denton, Md.

23. FUNERAL DIRECTOR: Wright Trowbridge
ADDRESS: Denton Md

24a. REC'D BY REGISTRAR DATE NOV 22 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please state the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent; prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12408

CERTIFICATE OF DEATH

12430 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Caroline — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg
c. LENGTH OF STAY IN 1b: Full Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First L. Middle Claude Last Covey

4. DATE OF DEATH: Month Nov. Day 1 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 16, 1904

9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housepainter

10b. KIND OF BUSINESS OR INDUSTRY: Painter

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Luther H. Covey

14. MOTHER'S MAIDEN NAME: Nancy Nichols

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 220-10-9985

INFORMANT: Mrs. Virginia Covey Address: Federalsburg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO (b): Chronic Myocarditis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 1, 1960, to Nov 1, 1960, that I last saw the deceased alive on Nov 1, 1960, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: F. M. Anderson M.D. ADDRESS (Street, city or town, state): Federalsburg, Md. DATE SIGNED: 11/2/60

PHYSICIAN'S NAME (Type): F. M. Anderson.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 4, 1960

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest

22d. LOCATION (City, town, or county) (State): Federalsburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Harvey Williams ADDRESS: Federalsburg, Md.

24a. REC'D BY REGISTRAR DATE: NOV 7 '60

24b. REGISTRAR'S SIGNATURE: Esther L. Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12435 — Reg. Dist. No. 12409

1. PLACE OF DEATH
a. COUNTY: CAROLINE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL GREENSBORO
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X DENTON
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OCTAVIA Middle — Last FLAMER

4. DATE OF DEATH: Month Nov Day 27, Year 1960

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 27, 1866

9. AGE (In years last birthday): 94 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic Servant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Wayman

14. MOTHER'S MAIDEN NAME: Sarah W Wyatt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Lizzie Brown — Address: Denton Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocarditis, Senile — INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized Arteriosclerosis — Several Mts.
DUE TO
(c): — Several Yrs
450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 19 60, to Nov 19 60, that I last saw the deceased alive on Nov 19 60, and that death occurred at 9 A M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

ACTUAL SIGNATURE: Dawson D George M.D. — DATE SIGNED: 11-29-60

PHYSICIAN'S NAME (Type): DAWSON D GEORGE M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec 1, 1960

22c. NAME OF CEMETERY OR CREMATORY: Springrove

22d. LOCATION (City, town, or county) (State): Denton Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Wright Moreton Denton Md.

24a. REC'D BY REGISTRAR DATE: DEC 5 '60

24b. REGISTRAR'S SIGNATURE: C. Wm S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12432

CERTIFICATE OF DEATH

12410

1. PLACE OF DEATH — a. COUNTY: Caroline — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Caroline

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greensboro

c. LENGTH OF STAY IN 1b: 14 Yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greensboro

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: None

d. STREET ADDRESS: 1 Sunset Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillian — Middle: Virginia — Last: Ginn

4. DATE OF DEATH: Month: 11 — Day: 21 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 3-20-1898

9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George H. Ginn

14. MOTHER'S MAIDEN NAME: Rosa Goldsborough

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Miss Mildred Ginn Greensboro, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:

420 r 1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Cardiovascular Dis.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatoid Arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 20 1960 to Nov. 21 1960 that (I) (we) last saw the deceased alive on Nov. 21 1960, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Charles H Stonesifer M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 11/22/60

22c. PHYSICIAN'S NAME (Type): Charles H. Stonesifer, M.D.

22d. ADDRESS: Greensboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 11-23-60

23c. NAME OF CEMETERY OR CREMATORY: Townsend

23d. LOCATION (City, town, or county) (State): Townsend, Delaware

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. E. Boulais Greensboro, Md.

25a. REC'D BY REGISTRAR — DATE: NOV 28 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12433 — Reg. Dist. No. 12411

1. PLACE OF DEATH
a. COUNTY: Caroline — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greensboro
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION: Mrs Cahall Guest Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Queen Annes
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Centreville — 17 X - 2
d. STREET ADDRESS: 303 S. Liberty St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CARLOTTA Middle ELIASON Last LEGG

4. DATE OF DEATH: Month Nov Day 15 Year 1960

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: March 8-1876 — 9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Greensboro Maryland — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George W Gleason — 14. MOTHER'S MAIDEN NAME: Annie M Sangston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: none — 17. INFORMANT: J.H.E. Legg — Address: Centreville Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiovascular Renal Disease with hypertension — INTERVAL BETWEEN ONSET AND DEATH

4 4 2 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized Arteriosclerosis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 1, 1960, to Nov. 15, 1960, that I last saw the deceased alive on Nov. 15, 1960, and that death occurred at 5:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles H Stonesifer M.D. — ADDRESS (Street, city or town, state): Greensboro, Md. — DATE SIGNED: 11-17-60

PHYSICIAN'S NAME (Type): Charles H. Stonesifer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Nov 18. 1960 — 22c. NAME OF CEMETERY OR CREMATORY: Chesterfield — 22d. LOCATION (City, town, or county) (State): Centreville Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Radcliffe Boston Bros — ADDRESS: Centreville Md — 24a. REC'D BY REGISTRAR DATE: NOV 22 '60 — 24b. REGISTRAR'S SIGNATURE: Clotilda E Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12436

12412

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1 PLACE OF DEATH
a. COUNTY: Caroline — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Caroline

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Rural Ridgely

c. LENGTH OF STAY IN 1b: 1 yr.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Ridgely

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: None

d. STREET ADDRESS: None

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Albert Middle: Last: Morris

4. DATE OF DEATH: Month: November Day: 2 Year: 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 2, 1895

9. AGE (In years last birthday): 65 yrs

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Day Laborer

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Raymond Murrey Address: Ridgely, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:

420

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (b): Arteriosclerotic Cardiovascular

DUE TO (c): Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from Sept. 5, 1959, to Nov. 2, 1960, that (I) (we) last saw the deceased alive on Nov. 2 1960, and that death occurred at 9.30 AM, from the causes and on the date stated above

22a SIGNATURE: Charles H Stonesifer M D

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 11-3-60

22c PHYSICIAN'S NAME (Type): Charles H. Stonesifer, M.D.

22d ADDRESS: Greensboro, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 11-5-60

23c. NAME OF CEMETERY OR CREMATORY: Boonsboro

23d. LOCATION (City, town, or county) (State): Rural Ridgely, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: John E Boulais jr.

ADDRESS: Greensboro, Md.

25a REC'D BY REGISTRAR DATE: NOV 7 '60

25b REGISTRAR'S SIGNATURE: Arthur S Krauss

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1243 — 19413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: CAROLINE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL DENTON
c. LENGTH OF STAY IN 1b: MARYLAND 50 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL DENTON
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First HARRY Middle JONATHAN Last MURPHY

4. DATE OF DEATH: Month Nov. Day 15 Year 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: APR. 13, 1895

9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farm owner

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: WILLIAM MURPHY

14. MOTHER'S MAIDEN NAME: LIDA NOBLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes

(If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Harry Murphy Denton, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot Wound to R. Chest — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20e. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Carrying Loaded Gun on Tractor, Accidentally Was Charged

20c. TIME OF INJURY Hour a.m. Month, Day, Year: 11:45 — 11-15 1960

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm

20f. (City or town) Denton (County) Caroline (State) Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Dawson O. Gange M.D.

EXAMINER'S NAME (Type): Dawson O. Gange M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town, or county): Denton, Caroline

DATE SIGNED: Nov. 16. 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: NOV 19, 1960

22c. NAME OF CEMETERY OR CREMATORY: Concord

22d. LOCATION (City, town, or country): Concord, Md. (State)

23. FUNERAL DIRECTOR: J. Virgil Moore & Son

ADDRESS: Denton, Md.

24a. REC'D BY REGISTRAR DATE: NOV 22 '60

24b. REGISTRAR'S SIGNATURE: Julian L. Hines

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12431

12414

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1 PLACE OF DEATH
a. COUNTY: CAROLINE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FEDERALSBURG
c. LENGTH OF STAY IN 1b: 2 MONS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BROOKLYN AVE

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DELAWARE — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MAGNOLIA
d. STREET ADDRESS: R.F.D. 1 X 3
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3 NAME OF DECEASED (Type or print): First MARY — Middle EMILY — Last PRITCHETT

4. DATE OF DEATH: Month NOVEMBER — Day 15 — Year 1960

5 SEX: FEMALE

6 COLOR OR RACE: NEGRO

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: MARCH 27, 1889

9 AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months 7 — Days 21
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DAY LABORER

10b KIND OF BUSINESS OR INDUSTRY: CANNERY

11 BIRTHPLACE (State or foreign country): SUSSEX COUNTY, DEL.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: ANDREW CANNON

14 MOTHER'S MAIDEN NAME: LILY PINCKENS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 41-04190 80

17. INFORMANT: IDA ROBERTA BRIGGS — Address: FEDERALSBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): General Metastasis (Brain - Liver) — INTERVAL BETWEEN ONSET AND DEATH: 00-7459

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ost.

DUE TO (b): Primary Carcinoma Left Ovary.

DUE TO (c): involving - Uterus - Liver & Brain

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): This patient was only seen twice by Undersigned

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct 25, 1960 to Nov 18, 1960, that (I) (we) last saw the deceased alive on Nov 15 1960, and that death occurred at 2:15 P.M., from the causes and on the date stated above

22a. SIGNATURE: W. E. Lemmon M.D — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 11-21-60

22c. PHYSICIAN'S NAME (Type): W. E. Lemmon MD

22d. ADDRESS: Federalsburg Md

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Nov. 21, 1960

23c. NAME OF CEMETERY OR CREMATORY: FEDERAL HILL

23d. LOCATION (City, town, or county) (State): FEDERALSBURG MD.

24 FUNERAL DIRECTOR'S SIGNATURE: J. J. Frampton & Son — ADDRESS: Federalsburg, Md.

25a. RECD BY REGISTRAR DATE: NOV 28 '60

25b. REGISTRAR'S SIGNATURE: Arthur E. Fiscus

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12434

12415

1. PLACE OF DEATH
a. COUNTY: Caroline — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Caroline

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greensboro
c. LENGTH OF STAY IN 1b: 1 yr.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Greensboro

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cahall Rest Home
d. STREET ADDRESS: 1 Sunset Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna Middle: Last: Seward
4. DATE OF DEATH: Month: November Day: 1 Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 8, 1876
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Carrie Dabson Address: Greensboro, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Chronic Nephritis	
422.1		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Chronic Myocarditis	
DUE TO (c)	Generalized Arteriosclerosis	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Bronchitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 15, 1958, to Nov. 1, 1960, that (I) (we) last saw the deceased alive on Oct. 31 1960, and that death occurred at 4 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Charles H. Stonesifer M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 11/1/60
22c. PHYSICIAN'S NAME (Type): Charles H. Stonesifer, M.D.
22d. ADDRESS: Greensboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-3-60
23c. NAME OF CEMETERY OR CREMATORY: Greensboro
23d. LOCATION (City, town, or county) (State): Greensboro, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John E. Boulais, Jr.
ADDRESS: Greensboro, Md.
25a. REC'D BY REGISTRAR DATE: NOV 3 '60
25b. REGISTRAR'S SIGNATURE: Charles L. Turner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12438

CERTIFICATE OF DEATH

12416

1 PLACE OF DEATH
a. COUNTY: Caroline — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Caroline

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Goldsboro

c. LENGTH OF STAY IN 1b: 60 Yrs.

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Goldsboro

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: None

d. STREET ADDRESS: None

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Noble Middle: J. Last: Shively

4. DATE OF DEATH: Month: 11 Day: 16 Year: 19 60

5 SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-10-1892

9. AGE (In years last birthday): 68 yrs

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor-Builder

10b. KIND OF BUSINESS OR INDUSTRY: Carpenter

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James W. Shively

14 MOTHER'S MAIDEN NAME: Lydia Dennison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 218-20-4352

17 INFORMANT: Mae B. Shively Address: Goldsboro, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACHEXIA FROM MULTIPLE METASTASES — INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS

DUE TO (b) CARCINOMA OF PROSTATE — 1 YEAR

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 10/13 1959 to 11/16 1960, that (I) (we) last saw the deceased alive on 11/15 1960, and that death occurred at 6 A M, from the causes and on the date stated above.

22a SIGNATURE: Robert H. Wright M.D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 11/18/60

22c PHYSICIAN'S NAME (Type): ROBERT H. WRIGHT, M.D.

22d. ADDRESS: GREENSBORO, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 11-19-60

23c NAME OF CEMETERY OR CREMATORY: Greensboro

23d LOCATION (City, town, or county) (State): Greensboro, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: J. E. Williams Funeral Home ADDRESS: Md

25a. REC'D BY REGISTRAR DATE: NOV 21 '60

25b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12439 12417

1. PLACE OF DEATH
a. COUNTY Caroline MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - Preston
c. LENGTH OF STAY IN 1b 10 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Preston
d. STREET ADDRESS 1 Rural
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Carrie Middle — Last Washington
4. DATE OF DEATH Month 11 Day 24 Year 1960
5. SEX F
6. COLOR OR RACE C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3-15-90
9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Washington
14. MOTHER'S MAIDEN NAME Margaret Smith
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 213-22-5781
17. INFORMANT Mary L. Sharp Address Route 2 Box 182 Preston, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute left ventricular failure	Minutes
DUE TO (b)	Aortic insufficiency & stenosis	8 yrs
DUE TO (c)	Arteriosclerotic heart disease	10-15 yrs

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 1952 to Nov. 24 1960 that (I) (we) last saw the deceased alive on Nov 15 1960 and that death occurred at 7 A M, from the causes and on the date stated above.

22a. SIGNATURE Harry B. Plummer M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 11/28/60
22c. PHYSICIAN'S NAME (Type) DR. H. B. Plummer
22d. ADDRESS Preston Md.

23a. BURIAL, ~~CREMATION~~, ~~REMOVAL (Specify)~~ Burial 23b. DATE THEREOF 11-29-60 23c. NAME OF CEMETERY ~~OR CREMATORY~~ Harmony Cem. 23d. LOCATION (City, town, or county) (State) Preston, Md.

24. FUNERAL DIRECTOR'S SIGNATURE James B. Caliel ADDRESS Easton, Md.
25a. REC'D BY REGISTRAR DATE DEC 5 '60 25b. REGISTRAR'S SIGNATURE Curtis L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12421 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12418

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please state the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: CAROLINE — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): DENTON
   c. LENGTH OF STAY IN 1b: 1 hr
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: CAROLINE
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL GREENSBORO
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JOHN Middle Last WITBAK

4. DATE OF DEATH: Month NOV. Day 29 Year 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: JUNE 9, 1904

9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DRAUGHTSMAN

10b. KIND OF BUSINESS OR INDUSTRY: LUMBER

11. BIRTHPLACE (State or foreign country): Penna

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: KARL WITBAK

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs John Witbak Address: Greensboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Several yrs.
420.1
DUE TO (b): Coronary Occlusion — Immediate
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ACTUAL SIGNATURE: Dawson O George M.D.

EXAMINER'S NAME (Type): Dawson O. George M.D.

Address (Street, city, town, or county):

DATE SIGNED: 11-29-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec 1, 1960

22c. NAME OF CEMETERY OR CREMATORY: Denton

22d. LOCATION (City, town, or county) (State): Denton Md.

23. FUNERAL DIRECTOR: J. Wright Moore & Son ADDRESS: Denton Md.

24a. REC'D BY REGISTRAR DATE: DEC 5 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus